The Pharmacist Activist

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Editorial

Our Profession's Own Pharmacy Care Administrator (PCA): Part 4

Most of the responses I have received to my last three editorials have voiced strong support for our profession establishing our own pharmacy care administrator. The criticism and outrage regarding most of the prescription benefit programs continue to escalate, with additional examples of abuses and deception being reported. In Part 3 of this series of editorials, I reported the comment of a CVS spokesman that ". . . CVS Caremark passes along more than 90 percent of the price discounts it receives directly to its clients." A pharmacist with extensive experience with prescription plans responded that this statement actually refers to " . . . 90% of what they CALL discounts," and he proceeded to identify multiple fees and rebates that are extracted by a PBM and are separate from the amount it chooses to identify as the discount. This pharmacist and others are enthusiastic about participating in establishing our own PCA. However, some others do not feel this is possible.

Several pharmacists have shared experiences regarding their personal participation in prescription programs that were designed to promote the services of pharmacists and provide equitable compensation, and their subsequent frustration when the programs were not successful or were sold to another company that did not have the same priorities. One respondent is disgusted and disillusioned after having committed extensive personal resources and time over a period of almost 30 years in efforts to get pharmacists to work together for their own benefit and that of patients and our profession. He is particularly critical of independent pharmacists for not doing enough to support legislative and programmatic initiatives that are urgently needed and could increase the likelihood of their financial survival. Although the number of independent pharmacies has declined to the point that they are not directly competing with each other, this individual makes the case that many wholesalers and buying groups with which independent pharmacies are affiliated are fierce competitors who often actively oppose efforts to bring larger numbers of pharmacists together in closer working relationships. He concluded his first message to me by noting: "You can pipe dream anything and there will be those who commend your writings and tell you how wonderful it sounds. Then count on 1% to join. Have a joint and relax. The industry is self-destructing and no one will alter the behavior of pharmacists."

I responded to this individual by commending him for all he has done in spite of so much of his experience being frustrating (and also noted that I would not resort to having a joint). My response also included the following observations:

> "You provide a number of examples of concern and frustration but have not provided any ideas for a better alternative. I am not yet willing to give up searching (dreaming) for a better alternative, and my sense is that you have not completely given up either or you would not have taken the time you did to respond to me. It is very discouraging that most independent pharmacists don't strongly participate in efforts in which they could benefit. However, I hesitate to strongly fault them because

they are getting beaten up by all the marketplace forces, and they have represented our profession to the public more effectively than those of us in other areas of the profession have . . . . I feel that the issues and challenges for pharmacy are so important that we can't give up fighting."

To his credit, he responded at length in sharing additional experiences and helpful recommendations, and also demonstrating that he has not given up fighting either.

Pertinent events

In just the one month that has elapsed since I wrote the July editorial, there are additional examples of the continuing problems inherent in the current prescription programs, as well as other pertinent events and commentaries, including the following:

- Proposed class-action lawsuits have been filed against CVS and Walgreens on behalf of consumers who allege that they have been charged more for generic drugs in their prescription benefit plan than if they had not used their prescription insurance card. The initial lawsuit against CVS was subsequently dropped but the attorney plans to refile a lawsuit against CVS related to its pricing of generic drugs.
- Walgreens and Rite Aid – The revised proposed acquisition by Walgreens of a smaller number (2,186) of Rite Aid stores (please see the July issue of *The Pharmacist Activist*) was withdrawn and refiled. The deadline by which the Federal Trade Commission (FTC) would have had to provide a request for additional information about the planned acquisition was August 18. To avoid what might have resulted in a considerable delay in FTC action if it made such a request, the withdraw and refiling action by Walgreens and Rite Aid now extends the deadline for FTC to make such a request until September 18, prior to which the chains hope to be able to respond to any FTC questions/issues in a way that will result in a favorable action. As I have noted previously, the proposed acquisition should be viewed as anticompetitive and the FTC should take action to prevent it.
- In December, 2016 the *Chicago Tribune* published the results of its investigation that concluded that more than 50% of 255 chain and independent pharmacies visited by its reporters failed to identify potentially serious interactions between two medications for which prescriptions were presented (please see my editorials in the January and February issues of *The Pharmacist Activist*). Largely in response to this investigation, the state of Illinois has implemented new regulations this month that require pharmacists to provide verbal counseling when dispensing prescriptions to new patients, provide a new medication to a current patient, and provide a current prescription in which there are changes in the dosage, potency, or directions. Chain pharmacies have responded with comments that they have upgraded their computer alert systems, provided additional training for their pharmacists, and that patient safety is their highest priority. However, I am not aware of any chain responding that they have increased their staffing of pharmacists and technicians, or altered or eliminated the metrics their stores are expected to accomplish.
- The abusive and deceptive policies and tactics of the PBMs, insurance companies, and their prescription programs are only getting worse. PBM programs are excluding an increasing number of pharmacies from their networks, pharmacies that continue in the networks must contend with increased restrictions, compensation is reduced, retaliatory audits are common, and the options for patients are increasingly restricted. As an example of the latter situation, some PBM programs, in addition to providing financial incentives to use mail-order or local pharmacies they own, will not provide coverage for maintenance medications in an in-network pharmacy other than the ones they own beyond the first two 30-day supplies of the medication.
- A pharmacist has made me aware of a commentary by CNBC senior columnist Jake Novak (Twitter @ jakejakeny) titled, "How hospitals could kill the health insurance industry." Although this commentary does not address prescription benefits and programs, it provides very thought-provoking observations regarding the symbiotic relationship between hospitals and insurance companies that " . . . helps perpetuate the hospitals' ability to control prices and the insurance companies' ability to convince almost everyone in America that they need their product."

On a positive note, I have become more aware of the Community Pharmacy Enhanced Services Network (CPESN: www.cpesn.com), the leadership of which includes pharmacists whom I hold in high regard. This initiative is in various stages of implementation in many states, and focuses on strong pharmacist/patient relationships, the provision of comprehensive pharmacist services and improvement of patient health outcomes, and equitable compensation for pharmacists. This program appears to have the potential for synergies with the concept of the PCA I am advocating, and I need to learn more about it.

(Continued on Page 4)

New Drug Review

Plecanatide
(Trulance – Synergy)

Agent for Constipation

New Drug Comparison Rating (NDCR) = 3
(no or minor advantages/ disadvantages)
in a scale of 1 to 5 with 5 being the highest rating

Indication:
Treatment of chronic idiopathic constipation (CIC) in adults.

Comparable drug:
Linaclotide (Linzess).

Advantages:
- May be administered without regard to food (whereas linaclotide should be administered on an empty stomach at least 30 minutes prior to the first meal of the day).

Disadvantages:
- Labeled indications are more limited (linaclotide is also indicated for the treatment of irritable bowel syndrome with constipation).

Most important risks/adverse events:
Risk of serious dehydration in pediatric patients (boxed warning; contraindicated in patients less than 6 years of age, and use should be avoided in patients 6 years to less than 18 years of age); contraindicated in patients with known or suspected mechanical gastrointestinal obstruction; severe diarrhea (if experienced, treatment should be suspended and the patient rehydrated).

Most common adverse events:
Diarrhea (5%).

Usual dosage:
3 mg once a day; tablets should be swallowed whole; for patients with swallowing difficulties, the tablets may be crushed and administered orally either in applesauce or with water, or administered with water via a nasogastric or gastric feeding tube; product labeling should be consulted for the specific preparation and administration instructions.

Products:
Tablets – 3 mg; should be dispensed in the original bottle and not repackaged or subdivided; should be protected from moisture and the desiccant should not be removed from the bottle; also supplied in unit dose blister packs.

Comments:
Individuals who experience persistent constipation (i.e., for more than 6 months) for which there is no apparent explanation (e.g., obstruction, use of medications such as opioids) are diagnosed as having chronic idiopathic constipation (CIC). CIC does not typically respond to standard treatment such as laxatives. Medications with a labeled indication for CIC include linaclotide and lubiprostone (Amitiza).

Plecanatide is a 16-amino acid peptide with properties that are most similar to those of linaclotide. Both agents act as guanylate cyclase-C (GC-C) agonists, and they and their active metabolites bind to GC-C and act locally on the luminal surface of the intestinal epithelium. Activation of GC-C results in an increase in both intracellular and extracellular concentrations of cyclic guanosine monophosphate (cGMP). Elevation of intracellular cGMP stimulates secretion of chloride and bicarbonate into the intestinal lumen, resulting in increased intestinal fluid and accelerated transit. A change in stool consistency occurs, and intestinal pain may be reduced.

The effectiveness of plecanatide was demonstrated in two 12-week placebo-controlled studies. The primary endpoint was defined as a patient who had at least 3 complete spontaneous bowel movements (CSBMs) in a given week and an increase of at least 1 CSBM from baseline in the same week for at least 9 weeks out of the 12-week treatment period and at least 3 of the last 4 weeks of the study. There was a 21% responder rate in both studies in patients treated with plecanatide, compared with 10% and 13% of the patients receiving placebo. Improvements in the frequency of CSBMs/ week were seen as early as week 1, and improvements in stool frequency and consistency and straining were also experienced. Plecanatide is minimally absorbed and systemic availability is negligible.

Daniel A. Hussar

The new PCA

I understand and respect the comments of those who consider the establishment of the PCA I am advocating to be naïve, unrealistic, and/or impossible. However, notwithstanding exceptional accomplishments of a number of individual pharmacists that provide valuable practice models, these situations are isolated rather than common, and are lacking the infrastructure or supportive organizations that will result in widespread increases in the standards of pharmacy practice. I have been searching and listening for ideas and recommendations that a large number of pharmacists would support financially, and with their time and activism. But I am not hearing ideas that I consider to have a greater potential for positive outcomes than our profession establishing its own PCA.

Can we design a better pharmacy care administration program? **Absolutely!**
Can such a program provide equitable compensation for pharmacists and also be financially competitive? **Yes!**
Are there enough pharmacy leaders with the vision, wisdom, experience, and commitment to establish this program? **Probably.**
Will enough community pharmacists invest and participate in the program? **Maybe.**

The establishment of a new and successful PCA would be highly dependent on the active commitment, participation, and investment of a large number of independent pharmacists, but also represents an important investment in their own future and perhaps the survival of independent pharmacy. I consider it essential that participating pharmacists have a financial investment in the new PCA in a manner/structure in which some currently participate in wholesaler collaboratives. This should assure continued ownership of the PCA within the profession, and also provide the motivation for wanting the investment to be successful and participating accordingly. The shared ownership arrangement may also increase the opportunities for negotiating more favorable arrangements with pharmaceutical companies, insurance companies, etc. It is also extremely important that the quality and scope of professional services provided by pharmacists exceed and be clearly superior to those currently provided. Some owners of independent pharmacies may be satisfied with the services they provide now, or be hesitant or intimidated by the prospect of expanding services to meet the criteria to participate in the new program. This situation must be addressed by the leadership of the PCA and our professional organizations by providing programming and services in which interested pharmacists may acquire the needed knowledge and skills. For pharmacist owners who do not have the time or otherwise are not interested or in a position to personally participate in such programs, arrangements should be identified through which pharmacists with these skills can be retained on a part-time basis.

What services should be provided in the pharmacies participating in the new PCA? Let's start with the following:

- Personal (i.e., face-to-face with the patient or caregiver) communication/counseling regarding health issues, prescription medications, and self-care products;
- Delivery of medication and house calls/visits as appropriate;
- Medication synchronization program (i.e., appointment-based model);
- Medication review for potential problems (e.g., drug interactions, unneeded medications, errors);
- Monitoring of compliance/adherence;
- Assessment of health and therapeutic outcomes;
- Appropriate communication with other health providers providing care for the patients served;
- Immunization services;
- Medication therapy management (MTM) for patients with certain medical problems (let's initially identify diabetes, hypertension, hyperlipidemias, asthma, chronic pain);
- Smoking cessation and substance use prevention/treatment consultation.

Are there enough of us who are dreaming of a better pharmacy world to make a new PCA a reality?

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